OMB Control Number: 2900-0822
Estimated Burden: 15 minutes
Expiration Date: XX/XX/20XX

Department of Veterans Affairs — Camp Lejeune Family Member Program Claim Form

Attention: *After reviewing the following information, complete the form in its entirety (print or type only), and return with the itemized billing statements to the Department of Veterans Affairs, Financial Services Center, PO Box 149200, Austin TX, 78714-9200. Customer Service Center: 1-866-372-1144, Fax: 512-460-5536.*

Claim form usage: This form is to be completed by the patient, sponsor, or guardian and is mandatory for all beneficiary claims. This claim form is NOT to be used for provider submitted claims.

Other health insurance (OHI): If OHI exists, attach OHI's Explanation of Benefits (EOB) to the provider's itemized billing statement(s). Dates of service and provider charges on EOB must match billing statements.

Timely filing requirement: Claims must be received no later than two years after the date of service or, in the case of inpatient care, within two years of the discharge date.

Itemized billing statements: An itemized statement must be attached and contain:

- patient name, date of birth, and Member Number (same as patient's Social Security number);
- provider name, degree, tax identification number (TIN), address and telephone number; and
- service dates, itemized charges and appropriate procedure/diagnosis codes for each service (i.e. CPT-4, HCPCS, and ICD-9-CM codes), including narrative descriptions. Pharmacy claims are to include name, quantity, strength, and NDC of each drug.

Section I - Patient Information

Last Name	First Name	MI	Social Security Number

Street Address	☐ Check if New	Date of Birth (mm/dd/yyyy)

City	State	Zip Code	Telephone Number (include area code)

Section II - Other Health Insurance (OHI) Information

By law, other coverage must be reported. If more space is needed, please continue in the same format on a separate sheet.

- Was treatment for a work-related injury or condition? ☐ Yes ☐ No
- Was treatment for an injury or accident outside of work? ☐ Yes ☐ No

- Are you covered by other primary health insurance to include coverage through a family member (supplemental or secondary insurance excluded)?
  - ☐ Yes (check type below and provide coverage information on the right)
    - ☐ employer sponsored (group)
    - ☐ private (non group)
    - ☐ Medicare (Part A or B)
    - ☐ other (specify) _____
  - ☐ no (proceed to Section III)

Name of Other Health Insurance (OHI)

OHI Policy Number	OHI Telephone Number (include area code)

Name of Other Health Insurance (OHI)

OHI Policy Number	OHI Telephone Number (include area code)

Section III - Veteran Information

Last Name	First Name	MI	Social Security Number

Section IV - Claimant Certification

Federal Laws (18 USC 287 and 1001) provide for criminal penalties for knowingly submitting or making false, fictitious, or fraudulent statements or claims.

I certify that the above information and attachments are correct and represent actual services, dates, and fees charged. (Sign and date on right.) If certification is signed by a person other than the patient, complete the information the signature and date.

Signature (type if electronic)	Date

Last Name	First Name	MI	Relationship to Patient

Street Address

City	State	ZIP Code	Telephone Number (include area code)

Camp Lejeune Family Member Program Claim Form (Continued)

VA Burden Statement: An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid OMB control number. The OMB control number for this project is 2900-0822, and it expires XX/XX/20XX. Public reporting burden for this collection of information is estimated to average 15 minutes per respondent, per year, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate and any other aspect of this collection of information, including suggestions for reducing the burden, to VA Reports Clearance Officer at **vapra@va.gov**. Please refer to OMB Control No. 2900-0822 in any correspondence. Do not send your completed VA Form 10-10068a to this email address.

Privacy Act Information: The authority for collection of the requested information on this form is 38 USC 1787. The purpose of collecting this information is to determine your eligibility for reimbursement of health care related to conditions determined to result from contaminated water while you resided at Camp Lejeune, North Carolina, for a period of at least 30 days. The information you provide may be verified by computer matching programs with authoritative sources such as the Civilian Health and Medical Program of the Department of Veterans Affairs (CHAMPVA), Department of Defense (DoD), Defense Enrollment Eligibility Reporting System (DEERS), Centers for Medicare & Medicaid Services (CMS) or any other applicable authoritative source at any time. You are requested to provide your social security number as your VA record is filed and retrieved by this number. The responses you submit are considered private and may be disclosed outside VA only if the disclosure is authorized under the Privacy Act, including the routine uses identified in the VA system of records number 23VA16. For example, information including your social security number may be disclosed to the Department of Defense, contractors, trading partners, health care providers and other suppliers of health care services to determine your eligibility for medical benefits and payment for services.